

# Referral Form

## GPS<sup>2</sup> Specialist Opinion Service

To make a referral to the GPS<sup>2</sup> specialist opinion service please complete this form and send by either:

Post: GPS<sup>2</sup>, PO Box 10059 Adelaide Business Centre, Adelaide SA 5000

Email: [contact@gps2.com.au](mailto:contact@gps2.com.au)

Fax: 1800 477 245

Alternatively, please call us on 1800 477 246 if you prefer to make a referral by telephone, or if you have any questions or need assistance with completing this form. We will also accept a referral letter from General Practitioners in their preferred style but may need to contact your practice if any additional information is required.

Please feel free to call us should you require clinical advice via a further (follow-up) telephone call or to make an appointment for your patient to be reviewed or reassessed by the GPS<sup>2</sup> Specialist.

DETAILS OF PERSON MAKING REFERRAL		
Name:	Position:	
Organisation:		
Mailing Address:		
Email:	Phone:	Date:
GPS <sup>2</sup> Specialist Type(s) <i>(please tick one or more boxes to indicate the type of specialist required)</i>		
<input type="checkbox"/> Occupational Physician	<input type="checkbox"/> General Physician	<input type="checkbox"/> Psychiatrist
<input type="checkbox"/> Pain Physician		
<input type="checkbox"/> Orthopaedic Surgeon	<input type="checkbox"/> Other	If other, please specify:.....

GENERAL PRACTITIONER CONTACT DETAILS		
GP/Treating Doctor Name:		
Email:	Phone:	Fax:
Mailing Address:		

PATIENT DETAILS		
Name:	Date of Birth:	Mobile:
Home Address:		
Claim Number:	Insurer Name:	
Interpreter Required? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, please specify:.....		
Date of Injury or First Incapacity:	Is the Claim Accepted? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undetermined <input type="checkbox"/> Not sure	

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### PRESENTING CONDITION(S)

Please use this section to provide any of the following detail that you consider helpful for the Specialist to know.

For example:

- > *Injury description or Diagnosis*
- > *Relevant clinical findings and Investigation results*
- > *Relevant past medical history, including surgeries and medication details*
- > *Summary of treatment/management to date*
- > *Current Capacity (Activities of Daily and Work Capacity)*
- > *Other Relevant Information (Issues/barriers/urgency)*

### CHECKLIST INFORMATION TO BE SENT TO GPS<sup>2</sup> PRIOR TO APPOINTMENT *(Please tick which ones apply)*

<input type="checkbox"/> Medical certificates (especially most current)	<input type="checkbox"/> Radiology films/reports	<input type="checkbox"/> Laboratory/pathology results
<input type="checkbox"/> PBS/medication summary	<input type="checkbox"/> Clinical notes	<input type="checkbox"/> Specialist/surgical reports
<input type="checkbox"/> Treating provider reports	<input type="checkbox"/> Hospital discharge summaries	<input type="checkbox"/> Treatment/Rehabilitation plans
<input type="checkbox"/> Other, please specify:.....		

